**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

JESSE WILLIAM VREDENBURGH DO
745 KINGS POINT HARBOR
CORPUS CHRISTI TX 78402

**Respondent Name**

ARCH INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 19

**MFDR Tracking Number**

M4-12-2339-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Correct Modifiers…No fee reductions on DDE…Not affiliated w/network."

**Amount in Dispute:** $1,150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "We have escalated the bill for an additional review and our bill review company advises that no additional monies are due. They advise that per the TX state guidelines the bill allowance of zero is appropriate. One of the following modifiers must be billed by the provider in additional when billed with RE: Return to Work (RTW) modifier is present. W6-W9: Designated Doctor Examinations. The provider billed with modifier W5 (Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement). Provider needs to bill with the appropriate modifiers."

**Response Submitted by:** Gallagher Bassett Services, Inc., 6404 International Parkway, Suite 2300, Plano, TX 75093

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 21, 2011 | 99456-W5<br>99456-W5<br>99456-W8-RE | $300.00<br>$350.00<br>$500.00 | $0.00<br>$0.00<br>$500.00 |
| TOTAL | | $1,150.00 | $500.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 25, 2011
   - 4 – (4) – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 16 – (16) – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.

   Explanation of benefits dated September 15, 2011
   - 4 – (4) – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 16 – (16) – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.

**Issues**

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

**Findings**

1. The requestor billed the amount of $1,150.00 for CPT Code 99456-W5 for 13 body areas/units in box 24g of the CMS-1500, CPT Code 99456-W5 for 11 body areas/units in box 24g of the CMS-1500 and CPT Code 99456-W8-RE for 11 body areas/units in boxy 24g of the CMS 1500, for a Division ordered Designated Doctor examination. Review of the Division order on the EES-14 and DWC032 form was to determine Maximum Medical Improvement IMMI), determine impairment rating (IR) and to determine the ability of the employee to return to work. Review of the documentation supports that MMI was assigned and two (2) body areas were rated. The lumbar spine and the right ankle are the areas claimed as rated.

   CPT code 99456-W5 required a "WP" as an additional modifier for multiple impairment ratings.

   Per 28 Texas Administrative Code §134.204 states in part (j)(4)(C)(iii)

   (4) The following applied for billing and reimbursement of an IR evaluation.

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP". Reimbursement shall be 100 percent of the total MAR.

   28 Texas Administrative Code §134.204(k) states in pertinent part, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE'. In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports."

2. Review of the submitted documentation supports that the Division ordered the examination, yet any reimbursement methodology allowance per 28 Texas Administrative Code §134.204 for individual services was contingent upon the use of the modifiers explained in the entire rule. The medical bills submitted by the requestor for review does not reflect that the appropriate modifiers were applied to CPT Code 99456-W5 according to the rule, therefore, reimbursement is disallowed. However, review of the submitted documentation supports that the medical bills submitted by the requestor for review does reflect that the appropriate modifier was applied to CPT Code 99456-W8-RE according to the rule, therefore, reimbursement is allowed.

3. The respondent has previously reimbursed the amount of $0.00 for the disputed CPT codes 99456-W5 and 99456-W8-RE. The Division finds that CPT code 99456-W8-RE was appropriately billed. Therefore, the requestor is due a recommended reimbursement in the amount of $500.00.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $500.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | May 10, 2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.